

Guide for non-diabetes specialist physicians and primary care teams for cardiovascular risk optimization in patients with Type 2 diabetes and atherosclerotic cardiovascular disease (coronary artery disease, peripheral arterial disease, cerebrovascular disease)



Use available opportunities to review diabetes management and optimise cardiovascular risk – see Box 1

Newly diagnosed T2DM or established T2DM but treatment naive

Metformin first line (if eGFR>30)

T2DM on oral therapy only

Discuss complex cases with specialist diabetes team (e.g. if on 3 or more agents)

T2DM on insulin therapy

Involve specialist diabetes team in prescribing decisions-

Box 1: Healthcare essentials for Diabetes

Add in SGLT2 inhibitor or GLP1 receptor agonist with proven benefit in cardiovascular disease. See Box 2 for drug options and Boxes 3-4 for cautions in prescribing.

- Consider patient risk profile, preferences and drug characteristics when selecting between SGLT2i and GLP1-RA – see box 3 and box 4.
- Defer initiation until patient is stable following acute vascular events
- Counsel on omitting therapy when unwell – ‘sick day guidance’ and review after changing medication to assess tolerability and adherence

- Add the other class (SGLT2i or GLP1-RA) with cardiovascular benefit when treatment escalation is required
- Review HbA_{1c}, risk of hypoglycaemia (HbA_{1c} < 53 mmol/mol on insulin and/or SU), eGFR (check within current prescribing threshold) and cardiovascular risk factor profile
- Consider influence of diabetes therapies on cardiovascular risk when escalating treatment – see Box 5.
- Consider virtual multi-disciplinary team discussion in complex cases with multimorbidity



HbA_{1c}
Blood pressure
Lipid check
Eye screening
Foot screening
Kidney function (eGFR and ACR)

Advice on diet
Emotional & psychological support
Diabetes education
Care from diabetes specialists
Flu jab
Good care in hospital
Support with sexual problems
Help to stop smoking
Specialist care if planning pregnancy

Box 2	SGLT2 inhibitors (listed in alphabetical order)	GLP1 receptor agonists (listed in alphabetical order)
1 st line	Canagliflozin 100-300 mg daily Dapagliflozin 5- 10 mg daily Empagliflozin 10 -25 mg daily	Dulaglutide 0.75 - 1.5mg/weekly Liraglutide 0.6-1.8 mg daily Semaglutide 0.25-1.0mg/weekly
2 nd line	Ertugliflozin 15mg daily	Exenatide slow release (Bydureon) 2mg /weekly Lixisenatide 10-20 microg daily

Box 3 – SGLT2 inhibitors.

Greatest impact on heart failure and kidney disease outcomes and cardiovascular death. Modest BP and weight reduction. Good choice in patients with existing left ventricular dysfunction or kidney disease.

- Refer to current prescribing information for eGFR thresholds for initiation & continuation – likely to change to > 30 ml/min
- Provide education and advice leaflet. Counsel on risk of DKA, mycotic genital infections, UTI and importance of foot health (avoid in active foot sepsis-vascular disease).
- Avoid if previous or high risk for DKA (excess alcohol consumption, low body mass, ketogenic diet, pancreatic disease, eating disorder, recreational drug use, possible type 1 diabetes or LADA) or active foot complications.
- Avoid in women of childbearing age and advanced frailty or cognitive impairment
- If concern about volume depletion, consider diuretic dose reduction

Box 4 – GLP1 receptor agonists

Greatest impact on risk of stroke, myocardial infarction and cardiovascular death. Can lead to important weight loss – good choice in people with CVD and obesity.

- Requires education on injectable therapy.
- Avoid Semaglutide in severe retinopathy.

Box 5– effects of drugs on risk of cardiovascular events

Metformin	reduces
SGLT2 inhibitors	reduces
GLP1-receptor agonists	reduces
Pioglitazone	reduces (avoid in heart failure)
Sulphonylureas (SU)	neutral (risk of hypoglycaemia)
DPP4 inhibitors ('gliptins')	neutral (avoid saxagliptin in heart failure)